CSA Reimbursement Rate Certification
Residential Treatment and Treatment Foster Care

Name of Child: _____

Medicaid Number: _____

Residential Treatment or Treatment Foster Care Case Management Provider:

_____
(Provider Name)

_____

_____

Medicaid Provider Number: _____

Community Policy and Management Team:

Fauquier County
10 Hotel Street
Warrenton, VA 20186

I certify that the following rate, $_____ per day, has been negotiated for the above-named child for Medicaid reimbursable (check one):

☐ Residential Treatment
☐ Treatment Foster Care Case Management

The Medicaid rate noted above should reflect the negotiated rate minus expected reimbursement from all other payment sources, such as Title IV-E. The total of the reimbursement from all other sources cannot exceed the Medicaid maximum rate for this service. This rate shall be effective for dates of service beginning on _____/_____/_____
Month / Day / Year*

CPMT Signature: _____

Print Name: _____

Title _____

Date _____